Mental Health and Well Being Policy

1. Aims and Expectations

- *It is a primary aim of Wrenbury Primary School that every member of the school community feels valued and respected, and that each person is treated fairly and well. Our school ethos is firmly built on a belief that 'We all matter'. We are a caring community, whose values are built on mutual trust and respect for all, regardless of race and/or ethnicity. The school Mental Health and Wellbeing Policy is therefore designed to support the way in which all members of the school can live and work together in a supportive way. It aims to promote an environment where everyone feels happy, safe and secure, and where effective learning can take place.*

The Policy Aims to:

- Promote positive mental health in all staff and students
- Increase understanding and awareness of common mental health issues
- Alert staff to early warning signs of mental ill health
- Provide support to staff working with young people with mental health issues
- Provide support to students suffering mental ill health and their peers and parents/carers

1.1 At Wrenbury, we believe that all children are entitled to develop to their fullest potential academically, socially, emotionally and physically; enabling each child to grow in confidence and be able to fully participate in activities with confidence. It is widely recognised that a child's emotional health and wellbeing influences their cognitive development and learning, as well as their physical and social health and their mental wellbeing in adulthood. The Department for Education (DfE) recognises that, in order to help their pupils succeed: schools have a role to play in supporting them to be resilient and mentally healthy.

"Mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." (World Health Organization 2014)

At our school, we aim to promote positive mental health for every child, parent or carer and members of staff. We pursue this aim using both universal, whole school approaches and specialised, targeted approaches aimed at identified vulnerable pupils and families.

1.2 In addition to promoting positive mental health, we aim to recognise and respond to mental ill health. In an average classroom, three children will be suffering from a diagnosable mental health issue. At Wrenbury Primary School, by developing and implementing practical, relevant and effective mental health procedures, we believe that we can promote a safe and stable environment for children affected both directly, and indirectly by mental ill health. See **Appendix** for information and additional support about mental health illnesses.

1.3 This policy describes Wrenbury Primary School's approach to promoting whole school positive mental health and wellbeing and is intended as guidance for all staff including non-teaching staff and governors. It should be read in conjunction with our medical policy in cases where a pupil's mental health overlaps with or is linked to a medical issue, the SEND policy where a student has an identified special educational need and the safeguarding policy in relation to prompt action and wider concerns of vulnerability.

2.Staff

Our designated child protection / safeguarding officers are: Bessa Cador and Debbie Rowlands

Our mental health and pastoral lead is Bessa Cador supported by Rebecca Charlesworth.

Our CPD lead (in case people need training) is Bessa Cador / Debbie Rowlands.

3. Pupil Identification

Wellbeing measures include staff observations focusing on any changes in behaviour, attention and presentation. This will feed into the identification process as well as any communication from the pupils regarding their emotions and feelings. Any member of staff who is concerned about the mental health or wellbeing of a child should speak to the SENCO or mental health lead in the first instance. If there is a fear that the child is in danger of immediate harm then the normal safeguarding procedures should be followed with an immediate referral to the safeguarding lead staff or the head teacher. If the child presents a medical emergency then the normal procedures for medical emergencies should be followed, including alerting the first aid staff and contacting the emergency services if necessary. Where a referral to CAMHS is appropriate, this will be led and managed by the SENCO or mental health lead.

Individual support plans will identify and specific support for pupils causing concern or who receive a diagnosis pertaining to their mental health. Staff involved in the care of the pupil must follow recommendations in the plan. The plan should be drawn up involving the pupil, the parents and relevant health professionals.

The plan will include:

- Details of a pupil's condition
- Special requirements and precautions
- Medication and any side effects
- What to do, and who to contact in an emergency
- The role the school can play in relation to staff development and implementing support linked to policy and practice.

4. Procedure for Concern in relation to mental health issues.

If a pupil chooses to disclose concerns about their own mental health or that of a friend to a member of staff, the member of staff's response should always be calm, supportive and non-judgemental.

Staff should listen, rather than give advice and our first thoughts should be of the pupil's emotional and physical safety rather than of exploring 'Why?'

All disclosures should be recorded in writing and held on the pupil's confidential file in the Headteacher's office. This written record should include the date; the name of the member of staff to whom the disclosure was made; main points from the conversation and agreed next steps.

5. Confidentiality

We should be honest with regards to the issue of confidentiality. If we think it is necessary for us to pass our concerns about a pupil on then we should discuss with the pupil:

- Who we are going to talk to
- What we are going to tell them
- Why we need to tell them

6. Working with All Parents and Carers

Parents are often very welcoming of support and information from the school about supporting their children's emotional and mental health. In order to support parents we will:

- Highlight sources of information and support about common mental health issues on our school website.
- Ensure that all parents are aware of who they can to talk to, and how to get the support they need if they have concerns about their own child or a friend of their child.
- Make our mental health policy easily accessible to parents.
- Share ideas about how parents can support positive mental health in their children through our regular review meetings.
- Keep parents informed about the mental health topics their children are learning about in PSHEC and share ideas for extending and exploring this learning at home.

7. Staff Training and CPD

As a minimum, all staff will receive regular training about recognising and responding to mental health issues as part of their regular child protection training in order to enable them to keep students safe. We will point staff to relevant information for staff who wish to learn more about mental health through staff meetings and memos.

The MindEd www.minded.org.uk learning portal provides free online training suitable for staff wishing to know more about a specific issue. Training opportunities for staff who require more in depth knowledge will be considered as part of our performance management process and additional CPD will be supported throughout the year where it becomes appropriate due to developing situations with one or more pupils.

8. Policy Review

This policy will be reviewed every 3 years as a minimum.

Headteacher: B Cador
November 2017

To be reviewed: November 2020

Procedure

Appendices
Appendix 1:

Possible Warning Signs could include:
-Signs of physical harm
-Changes in behaviour
-Changes in mood
-Changes in eating
-Changes in sleeping
-Secretive behaviour
-Absences from school
-Lateness to school
-Reluctance to do P.E./changing clothes for P.E.
-Unusual clothing for time of year eg covering up in hot weather
-Emotional outbursts
-Lower attainment
-Poor motivation
-Social isolation

Appendix 2:
ALGEE process

1. Ask, assess, act

Where a young person is distressed, the member of staff should ask them what support they need and want. Assess the risk of harm to self or others and try to reduce any risk that is present.

2. Listen non-judgementally

Give them time to talk and gain their confidence to take the issue to someone who could help further

3. Give reassurance and information

Tell them how brave they have been. Gently explain that you would like to help them. Do not promise confidentiality - it could be a child protection matter.

4. Enable the young person to get help

Work through the avenues of support. Explain that you would like to share their thoughts with someone else so that they can get the best help. Encourage them to speak to someone - offer to go with them.

5. Encourage self-help strategies

Do not speak about your conversation or concerns with other pupils/casually to a member of staff.

Access support for yourself if you need it via a senior colleague or your line manager.

High Risk

If you consider the young person to be at risk then you should follow Child Protection procedures and report your concerns directly to the Designated Person (director of pastoral care).

The pastoral manager/SENCO will decide on the appropriate course of action. This may include:

Contacting parents/carers Arranging professional assistance e.g. doctor/nurse Arranging an appointment with a counsellor Arranging a referral to CAMHS - with parental consent Giving advice to parents, teachers and other students

Low Risk

If you feel that the young person needs a period of 'watchful waiting' communicate this to the Pastoral Manager or SENCO

After a period of watchful waiting, a pupil deemed to have continuing symptoms should be referred to a medical professional. This might be via the Consultation meetings or may be a specialist CAMHS referral

INDIVIDUAL CARE PLAN

Appendix 3:

What makes a good CAMHS referral?

If the referral is urgent it should be initiated by phone so that CAMHS can advise of best next steps

Before making the referral, have a clear outcome in mind, what do you want CAMHS to do? You might be looking for advice, strategies, support or a diagnosis for instance.

You must also be able to provide evidence to CAMHS about what intervention and support has been offered to the pupil by the school and the impact of this. CAMHS will always ask 'What have you tried?' so be prepared to supply relevant evidence, reports and records.

General considerations

- Have you met with the parent(s)/carer(s) and the referred child/children?
- Has the referral to CAMHS been discussed with a parent / carer and the referred pupil?
- Has the pupil given consent for the referral?
- Has a parent / carer given consent for the referral?
- What are the parent/carer pupil's attitudes to the referral?

Basic information

- Is there a child protection plan in place?
- Is the child looked after?
- Name and date of birth of referred child/children

- Address and telephone number
- Who has parental responsibility?
- Surnames if different to child's
- GP details
- What is the ethnicity of the pupil / family.
- Will an interpreter be needed?
- Are there other agencies involved?

Reason for referral

- What are the specific difficulties that you want CAMHS to address?
- How long has this been a problem and why is the family seeking help now?
- Is the problem situation-specific or more generalised?
- Your understanding of the problem/issues involved.

Further helpful information

- Who else is living at home and details of separated parents if appropriate?
- Name of school
- Who else has been or is professionally involved and in what capacity?
- Has there been any previous contact with our department?
- Has there been any previous contact with social services?
- Details of any known protective factors
- Any relevant history i.e. family, life events and/or developmental factors
- Are there any recent changes in the pupil's or family's life?
- Are there any known risks, to self, to others or to professionals?
- Is there a history of developmental delay e.g. speech and language delay
- Are there any symptoms of ADHD/ASD and if so have you talked to the Educational psychologist?

The screening tool on the following page will help to guide whether or not a CAMHS referral is appropriate. An SDQ form http://www.sdqinfo.com completed by school, parents and pupil is required for anonymous consultation reviews along with parental consent forms.

	INVOLVEMENT WITH CAMHS
	Current CAMHS involvement – **END OF SCREEN***
	Previous history of CAMHS involvement
	Previous history of medication for mental health issues
	Any current medication for mental health issues
	Developmental issues e.g. ADHD, ASD, LD

	DURATION OF DIFFICULTIES
	1-2 weeks
	Less than a month
	1-3 months
	More than 3 months
	More than 6 months

*** Ask for consent to telephone CAMHS clinic for discussion with clinician involved in young person's care**

Tick the appropriate boxes to obtain a score for the young person's mental health needs.

		MENTAL HEALTH SYMPTOMS
	1	Panic attacks (overwhelming fear, heart pounding, breathing fast etc.)
	1	Mood disturbance (low mood – sad, apathetic; high mood – exaggerated / unrealistic elation)
	2	Depressive symptoms (e.g. tearful, irritable, sad)
	1	Sleep disturbance (difficulty getting to sleep or staying asleep)
	1	Eating issues (change in weight / eating habits, negative body image, purging or binging)
	1	Difficulties following traumatic experiences (e.g. flashbacks, powerful memories, avoidance)
	2	Psychotic symptoms (hearing and / or appearing to respond to voices, overly suspicious)
	2	Delusional thoughts (grandiose thoughts, thinking they are someone else)
	1	Hyperactivity (levels of overactivity & impulsivity above what would be expected; in all settings)
	2	Obsessive thoughts and/or compulsive behaviours (e.g. hand-washing, cleaning, checking)

Impact of above symptoms on functioning - circle the relevant score and add to the total

Little or none	Score = 0	Some	Score = 1	Moderate	Score = 2	Severe	Score = 3

		HARMING BEHAVIOURS
	1	History of self harm (cutting, burning etc)
	1	History of thoughts about suicide
	2	History of suicidal attempts (e.g. deep cuts to wrists, overdose, attempting to hang self)
	2	Current self harm behaviours
	2	Anger outbursts or aggressive behaviour towards children or adults
	5	Verbalised suicidal thoughts* (e.g. talking about wanting to kill self / how they might do this)
	5	Thoughts of harming others* or actual harming / violent behaviours towards others

*** If yes – call CAMHS team to discuss an urgent referral and immediate risk management strategies**

Social setting - for these situations you may also need to inform other agencies (e.g. Child Protection)			
	Family mental health issues		Physical health issues
	History of bereavement/loss/trauma		Identified drug / alcohol use
	Problems in family relationships		Living in care
	Problems with peer relationships		Involved in criminal activity
	Not attending/functioning in school		History of social services involvement
	Excluded from school (FTE, permanent)		Current Child Protection concerns

How many social setting boxes have you ticked? Circle the relevant score and add to the total

0 or 1	Score = 0	2 or 3	Score = 1	4 or 5	Score = 2	6 or more	Score = 3

Add up all the scores for the young person and enter into Scoring table:

Score 0-4	Score 5-7	Score 8+
Give information/advice to the young person	Seek advice about the young person from CAMHS Primary Mental Health Team	Refer to CAMHS clinic

Appendix 4:
Prevalence of Mental Health and Emotional Wellbeing Issues[1]

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class.
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.
- There has been a big increase in the number of young people being admitted to hospital because of self harm. Over the last ten years this figure has increased by 68%.
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.
- Nearly 80,000 children and young people suffer from severe depression.
- The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.
- Over 8,000 children aged under 10 years old suffer from severe depression.
- 3.3% or about 290,000 children and young people have an anxiety disorder.
- 72% of children in care have behavioural or emotional problems - these are some of the most vulnerable people in our society.

Below, we have sign-posted information and guidance about the issues most commonly seen in school-aged children. The links will take you through to the most relevant page of the listed website. Some pages are aimed primarily at parents but they are listed here because we think they are useful for school staff too.

Support on all of these issues can be accessed via Young Minds (www.youngminds.org.uk), Mind (www.mind.org.uk) and (for e-learning opportunities) Minded (www.minded.org.uk).

Self-harm

Self-harm describes any behaviour where a young person causes harm to themselves in order to cope with thoughts, feelings or experiences they are not able to manage in any other way. It most frequently takes the form of cutting, burning or non-lethal overdoses in adolescents, while younger children and young people with special needs are more likely to pick or scratch at wounds, pull out their hair or bang or bruise themselves.

Online support

SelfHarm.co.uk: www.selfharm.co.uk
National Self-Harm Network: www.nshn.co.uk

Books

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

[1] Source: Young Minds

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2012) *A Short Introduction to Understanding and Supporting Children and Young People Who Self-Harm*. London: Jessica Kingsley Publishers

Depression

Ups and downs are a normal part of life for all of us, but for someone who is suffering from depression these ups and downs may be more extreme. Feelings of failure, hopelessness, numbness or sadness may invade their day-to-day life over an extended period of weeks or months, and have a significant impact on their behaviour and ability and motivation to engage in day-to-day activities.

Online support

Depression Alliance: www.depressionalliance.org/information/what-depression

Books

Christopher Dowrick and Susan Martin (2015) *Can I Tell you about Depression?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Anxiety, panic attacks and phobias

Anxiety can take many forms in children and young people, and it is something that each of us experiences at low levels as part of normal life. When thoughts of anxiety, fear or panic are repeatedly present over several weeks or months and/or they are beginning to impact on a young person's ability to access or enjoy day-to-day life, intervention is needed.

Online support

Anxiety UK: www.anxietyuk.org.uk

Books

Lucy Willetts and Polly Waite (2014) *Can I Tell you about Anxiety?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2015) *A Short Introduction to Helping Young People Manage Anxiety*. London: Jessica Kingsley Publishers

Obsessions and compulsions

Obsessions describe intrusive thoughts or feelings that enter our minds which are disturbing or upsetting; compulsions are the behaviours we carry out in order to manage those thoughts or feelings. For example, a young person may be constantly worried that their house will burn down if they don't turn off all switches before leaving the house. They may respond to these thoughts by repeatedly checking switches, perhaps returning home several times to do so. Obsessive compulsive disorder (OCD) can take many forms – it is not just about cleaning and checking.

Online support

OCD UK: www.ocduk.org/ocd

Books

Amita Jassi and Sarah Hull (2013) *Can I Tell you about OCD?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Susan Conners (2011) *The Tourette Syndrome & OCD Checklist: A practical reference for parents and teachers*. San Francisco: Jossey-Bass

Suicidal feelings

Young people may experience complicated thoughts and feelings about wanting to end their own lives. Some young people never act on these feelings though they may openly discuss and explore them, while other young people die suddenly from suicide apparently out of the blue.

Online support

Prevention of young suicide UK – PAPYRUS: www.papyrus-uk.org

On the edge: ChildLine spotlight report on suicide: www.nspcc.org.uk/preventing-abuse/research-and-resources/on-the-edge-childline-spotlight/

Books

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Terri A.Erbacher, Jonathan B. Singer and Scott Poland (2015) *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention*. New York: Routledge

Eating problems

Food, weight and shape may be used as a way of coping with, or communicating about, difficult thoughts, feelings and behaviours that a young person experiences day to day. Some young people develop eating disorders such as anorexia (where food intake is restricted), binge eating disorder and bulimia nervosa (a cycle of bingeing and purging). Other young people, particularly those of primary or preschool age, may develop problematic behaviours around food including refusing to eat in certain situations or with certain people. This can be a way of communicating messages the child does not have the words to convey.

Online support

Beat – the eating disorders charity: www.b-eat.co.uk/about-eating-disorders

Eating Difficulties in Younger Children and when to worry: www.inourhands.com/eating-difficulties-in-younger-children

Books

Bryan Lask and Lucy Watson (2014) *Can I tell you about Eating Disorders?: A Guide for Friends, Family and Professionals*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2012) *Eating Disorders Pocketbook*. Teachers' Pocketbooks

Appendix 5:
Further information:

Anxiety disorders

Anxiety is a natural, normal feeling we all experience from time to time. It can vary in severity from mild uneasiness through to a terrifying panic attack. It can vary in how long it lasts, from a few moments to many years.

All children and young people get anxious at times; this is a normal part of their development as they grow up and develop their 'survival skills' so they can face challenges in the wider world. In addition, we all have different levels of stress we can cope with - some people are just naturally more anxious than others, and are quicker to get stressed or worried.

Concerns are raised when anxiety is getting in the way of a child's day to day life, slowing down their development, or having a significant effect on their schooling or relationships. It is estimated that 1 in 6 people will suffer from General Anxiety Disorder at some point in their lives.

Anxiety disorders include:

- Generalised anxiety disorder (GAD)
- Panic disorder and agoraphobia
- Acute stress disorder (ASD)
- Separation anxiety
- Post-traumatic stress disorder
- Obsessive-compulsive disorder (OCD)
- Phobic disorders (including social phobia)

Symptoms of an anxiety disorder. These can include:

Physical effects

- Cardiovascular – palpitations, chest pain, rapid, heartbeat, flushing
- Respiratory – hyperventilation, shortness of breath
- Neurological – dizziness, headache, sweating, tingling and numbness
- Gastrointestinal – choking, dry mouth, nausea, vomiting, diarrhoea
- Musculoskeletal – muscle aches and pains, restlessness, tremor and shaking

Psychological effects

- Unrealistic and/or excessive fear and worry (about past or future events)

- Mind racing or going blank
- Decreased concentration and memory
- Difficulty making decisions
- Irritability, impatience, anger
- Confusion
- Restlessness or feeling on edge, nervousness
- Tiredness, sleep disturbances, vivid dreams
- Unwanted unpleasant repetitive thoughts Behavioural effects
- Avoidance of situations
- Repetitive compulsive behaviour e.g. excessive checking
- Distress in social situations
- Urges to escape situations that cause discomfort (phobic behaviour)

First Aid for anxiety disorders

Follow the ALGEE principles (see appendix 1)

How to help a student having a panic attack

- If you are at all unsure whether the student is having a panic attack, a heart attack or an asthma attack, and/or the person is in distress, call an ambulance straight away.

- If you are sure that the student is having a panic attack, move them to a quiet safe place if possible.

- Help to calm the student by encouraging slow, relaxed breathing in unison with your own.

- Encourage them to breathe in and hold for 3 seconds and then breathe out for 3 seconds.

- Be a good listener, without judging.

- Explain to the student that they are experiencing a panic attack and not something life threatening such as a heart attack.

- Explain that the attack will soon stop and that they will recover fully.

- Assure the student that someone will stay with them and keep them safe until the attack stops.

- Many young people with anxiety problems do not fit neatly into a particular type of anxiety disorder. It is common for people to have some features of several anxiety disorders. A high level of anxiety over a long period will often lead to depression and long periods of depression can provide symptoms of anxiety. Many young people have a mixture of symptoms of anxiety and depression as a result.

Depression

A clinical depression is one that lasts for at least 2 weeks, affects behaviour and has physical, emotional and cognitive effects. It interferes with the ability to study, work and have satisfying relationships. Depression is a common but serious illness and can be recurrent. In England if affects at least 5% of teenagers, although some estimates are higher. Rates of depression are higher in girls than in boys. Depression in young people often occurs with other mental disorders, and recognition and diagnosis of the disorder may be more difficult in children because the way symptoms are expressed varies with the developmental age of the individual. In addition to this, stigma associated with mental illness may obscure diagnosis.

- **Risk Factors:**

    - Experiencing other mental or emotional problems Divorce of parents
    - Perceived poor achievement at school
    - Bullying
    - Developing a long term physical illness
    - Death of someone close
    - Break up of a relationship

    Some people will develop depression in a distressing situation, whereas others in the same situation will not.

Symptoms

- Effects on emotion: sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, helplessness, hopelessness
- Effects on thinking: frequent self-criticism, self-blame, worry, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see you in a negative light, thoughts of death or suicide
- Effects on behaviour: crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation.
- Engaging in risk taking behaviours such as self harm, misuse of alcohol and other substances, risk-taking sexual behaviour.
- Physical effects: chronic fatigue, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight loss or gain, irregular menstrual cycle, unexplained aches and pains.

First Aid for anxiety and depression

Follow the ALGEE (principles see appendix 1)

The most important role school staff can play is to familiarise themselves with the risk factors and warning signs outlined above and to make the Pastoral Manager (designated teacher for safeguarding children) aware of any child causing concern.

Following the report, the Pastoral Manager will decide on the appropriate course of action. This may include:

- Contacting parents/carers
- Arranging professional assistance e.g. doctor, nurse
- Arranging an appointment with a counsellor
- Arranging a referral to CAMHS – with parental consent
- Giving advice to parents, teachers and other students

Students may choose to confide in a member of school staff if they are concerned about their own welfare, or that of a peer. Students need to be made aware that it may not be possible for staff to offer complete confidentiality. If you consider a student is at serious risk of causing themselves harm then confidentiality cannot be kept. It is important not to make promises of confidentiality that cannot be kept even if a student puts pressure on you to do so.

References

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